

BSN HESI 266 Med Surg Exam (New 2023/2024) Questions and Verified Answers|100% Correct| Graded A- Nightingale

QUESTION

A client who underwent cardiac stent placement four days ago arrives to the emergency department reporting a sudden onset of chest pressure and shortness of breath. Which action should the nurse take next?

- a. Listen for extra heart sounds, murmurs, and rhythm with the bell of the stethoscope.
- b. Evaluate upper and lower extremities for perfusion, pulse volume, and pitting edema.
- c. Verify troponin level assessments are scheduled every 3-6 hours for a series of three.
- d. Obtain a 12-lead electrocardiogram and begin continuous cardiac monitoring

Answer:

- d. Obtain a 12-lead electrocardiogram and begin continuous cardiac monitoring

QUESTION

While completing a health assessment for a client with migraine headaches, the nurse assesses bilateral weakness in the client's hand grips. The client reports joint pain and trouble twisting a door knob due to weaknesses. Which action should the nurses take in response to these figures?

- a. Implement fall precautions to reduce the client's risk of injury.
- b. Explain that relief of the migraine pain will reduce related symptoms.
- c. Gather additional assessment data about the pain and weakness.
- d. Consult with the occupational therapist for a functional assessment

Answer:

- c. Gather additional assessment data about the pain and weakness.

QUESTION

The nurse is caring for a client diagnosed with psoriasis vulgaris who is receiving psoralen and ultraviolet A light (PUVA) treatment. Which assessment finding indicates that the client has been overexposed to the treatment?

- a. Thick skin plaques topped by silvery white scales
- b. Tenderness upon palpation and generalized erythema
- c. Brown, rough, greasy, wart-like papules on the face

d. Requires sunglasses because sunlight hurts eyes

Answer:

b. Tenderness upon palpation and generalized erythema

QUESTION

An adult client who had a gastric bypass surgery 2 weeks ago, is admitted with possible anastomosis leakage. The client's abdomen is tender to touch, and the vital signs are temperature 101° F (38.3° C), heart rate 130 beats/minute, Respiratory rate 26 breaths/minute, and blood pressure 100/50 mmHg. Which intervention is most important for the nurse to include in the client's plan of care?

- a. Encourage regular turning.
- b. Monitor skin for breakdown.
- c. Strict IV fluid replacement
- d. Assess wound drainage daily

Answer:

c. Strict IV fluid replacement

QUESTION

A client who was recently diagnosed with Raynaud's disease is concerned about pain management. Which nursing instructions should the nurse provide?

- a. Painful areas should be rubbed gently until the pain subsides.
- b. Return appointments will be needed for IV pain medications.
- c. Enrolling in a pain clinic can provide relief alternatives.
- d. Wearing gloves when handling cold items guards against painful spasms.

Answer:

d. Wearing gloves when handling cold items guards against painful spasms.

QUESTION

A client with newly diagnosed Crohn's disease asks the nurse about dietary restrictions. How should the nurse respond?

- a. Explain that the need to restrict fluids is the primary limitation.
- b. Advise the client to limit foods that are high in calcium and iron.
- c. Instruct the client to avoid foods with gluten, such as wheat bread.
- d. Describe the use of an elimination diet to find trigger foods

Answer:

d. Describe the use of an elimination diet to find trigger foods

QUESTION

The nurse is obtaining a health history from a new client who has a history of kidney stones. Which statement by the client indicates an increased risk for renal calculi.?

- a. Jogs more frequently than usual daily routine.
- b. Eats a vegetarian diet with cheese 2 to 3 times a day.
- c. Experiences additional stress since adopting a child.
- d. Drinks several bottles of carbonated water daily

Answer:

b. Eats a vegetarian diet with cheese 2 to 3 times a day.

QUESTION

An older male client tells the nurse that he is losing sleep because he has to get up several times at night to go to the bathroom, that he has trouble starting his urinary system, and that he does not feel like his bladder is ever completely empty. Which intervention should the nurse implement?

- a. Review the client's fluid intake prior to bedtime.
- b. Obtain a finger stick blood glucose level.
- c. Palpate the bladder above the symphysis pubis.
- d. Collect a urine specimen for culture analysis

Answer:

c. Palpate the bladder above the symphysis pubis.

QUESTION

A client is diagnosed with chronic kidney disease and needs to begin dialysis. Which condition entered on the client's medical record should the nurse recognize as a contraindication for peritoneal dialysis?

- a. Nephrotic syndrome history.
- b. Latent hepatitis C.
- c. Crohn's disease with colectomy.
- d. Type 2 diabetes mellitus